01. Evaluation and Diagnostic Services. (7-1-93)

a. Medical/social, psychological, speech and hearing, physical, developmental, and occupational therapy evaluations must meet the requirements of IDAPA 16.04.11, "Rules and Minimum Standards Governing Developmental Disabilities Centers", with the following exceptions: (5-4-94)

i. For children being served in a Developmental Disabilities Center under Part H of IDEA (Individuals with Disabilities Education Act), the above evaluations must meet the requirements in Title 16, Chapter 1, Idaho Code, "Early Intervention Services" and the Idaho State Plan for Early Intervention of the Individuals with Developmental Disabilities Education Act; or (5-4-94)

ii. For children being served in a Developmental Disabilities Center under Part B of IDEA, the above evaluations must meet Section 33-201, Idaho Code, "School Age", and IDAPA 08.02.05240, "Special Education Programs." (5-4-94)

b. Twelve (12) hours is the maximum Medicaid reimbursable time allowed for the combination of all evaluation or diagnostic services provided in any calendar year. (10-6-88)

02. Treatment Services. Treatment services may be provided in the recipient's home when authorized by the physician in the plan of care. (5-4-94)

a. The treatment services must meet the requirements of IDAPA 16.04.11, "Rules and Minimum Standards for Developmental Disabilities Centers", with the following exceptions: (5-4-94)

i. For children being served in a Developmental Disabilities Center under Part H of IDEA, treatment services must meet the requirements in Title 16, Chapter 1, Idaho Code, "Early Intervention Services" and the Idaho State Plan for Early Intervention of the Individuals with Developmental Disabilities Education Act; or (5-4-94)

ii. For children being served in a Developmental Disabilities Center under Part B of IDEA, treatment services must meet Section 33-201, Idaho Code, "School Age", and IDAPA 08.02.05240, "Special Education Programs." (5-4-94)

b. Psychotherapy services limited to a maximum of forty-five (45) hours in a calendar year must be ordered by the physician, and include: (10-6-88)

i. Individual psychotherapy provided in accordance with the objectives specified in the written plan of care. (11-22-91)

ii. Group psychotherapy provided in accordance with the objectives specified in the written plan of care. (11-22-91)

iii. Family-centered psychotherapy which must include the recipient and one (1) other family member at any given time and must be delivered in accordance with objectives as specified in the written plan of care. (11-22-91)

iv. Psychotherapy services must be provided by licensed psychologists, physicians, psychology assistants, or by licensed social workers. (11-22-91)

c. Speech and hearing therapy services must be ordered by the physician, limited to two hundred fifty (250) treatment sessions per calendar year and delivered in accordance with the written plan of care. (11-22-91)

d. Physical therapy services must be ordered by the physician and are limited to one hundred (100) treatment visits per calendar year. Treatment must be provided by a licensed physical therapist and must be delivered in accordance with objectives as specified in the written plan of care. (11-22-91)

e. Developmental and occupational therapy services must be ordered by the physician and are limited to a maximum of thirty (30) hours per week. (10-6-88)

i. Occupational therapy must be delivered in accordance with objectives specified in the written plan of care. (11-22-91)

ii. Developmental therapy must be provided in accordance with objectives as specified in the written plan of care. (11-22-91)

f. Collateral contact with individuals directly involved with the recipient of service to expand rehabilitative services into the client's living location. Such contacts will be included in the limitations of hours of treatment service reimbursed by Medicaid. Contacts with such persons for the purpose of future placement, interagency and intra-agency case monitoring, staffings and social service activities are not allowable for Medicaid payment. (10-6-88)

g. Only one (1) type of therapy service will be reimbursed during a single time period by the Medicaid program. No therapy services will be reimbursed during periods when the recipient is being transported to and from the center. (10-6-88)

03. Optional Services. (11-22-91)

a. Consultation for the purpose of prescribing, monitoring, and/or administering medications. These consultations shall be: (11-22-91)

i. Provided by a physician or licensed nurse practitioner in direct face-to-face contact with the client; and (11-22-91)

ii. Incorporated into the client's individual service plan with the type, amount, and duration of the service specified. (11-22-91)

b. Nursing services for the purpose of supervising, monitoring, and/or administering medication within the limits of the Nurse Practice Act, Section 54-1402(d), Idaho Code. These services shall be: (11-22-91)

i. Ordered and supervised by a physician; and (11-22-91)

ii. Provided by licensed and qualified nursing personnel in direct face-to-face contact with the client; and (11-22-91)

iii. Incorporated into the client's individual service plan with the type, amount, and duration of the service specified. (11-22-91)

c. Psychiatric evaluations and services for the purpose of establishing a diagnosis, identifying client strengths and needs, and recommending and/or implementing interventions to address each need. These evaluations and services shall be: (11-22-91)

i. Conducted by a physician in direct face-to-face contact with the client; and (11-22-91)

ii. Incorporated into the client's individual service plan with the type, amount, and duration of service specified. (11-22-91)

04. Requirements for Centers. Centers must be licensed as Developmental Disabilities Centers by the Department. Loss of licensure by a center

will be cause for termination of all Medicaid program payment for services and termination of the center's provider agreement. (11-22-91)

05. Excluded Services. The following services are excluded for Medicaid payments: (10-6-88)

a. Vocational services; and (10-6-88)

b. Educational services; and (10-6-88)

c. Recreational services. (10-6-88)

06. Payment Procedures. Payment for center services must be in accordance with rates established by the Department. (11-10-81)

a. Providers of services must accept as payment in full the Department's payment for such services and must not bill a MA recipient for any portion of any charges. (11-10-81)

b. Third party payment resources, such as Medicare and private insurance, must be exhausted before the Department is billed for services provided to an eligible recipient. Proof of billing other third party payors is required. (11-10-81)

121. AMBULATORY SURGICAL CENTER. The Department will provide Ambulatory Surgical Centers (ASC) services for eligible recipients. Reimbursement and covered medical procedures will be based on Medicare program coverage and payment principles. (9-30-84)

01. Facility Approval. The ASC must be surveyed by the Department's Licensure and Certification Section as required by 42 CFR 416.25 through 416.49 and be approved by the U.S. Department of Health and Human Services for participation as a Medicare ASC provider. (9-30-84)

02. Provider Agreement. Following Medicare program approval, the Department may enter into a provider agreement with an ASC. No Medicaid payment may be made to any ASC in the absence of such an agreement. Grounds for cancellation of the provider agreement will include, but not be limited to: (9-30-84)

a. The loss of Medicare program approval will constitute grounds for cancellation of the Department's provider agreement with the ASC. (9-30-84)

b. Identification of any condition which threatens the health or safety of patients by the Department's Licensure and Certification Section will constitute grounds for cancellation of the Department's provider agreement with the ASC. (9-30-84)

03. Covered Surgical Procedures. Those surgical procedures identified by the Medicare program as appropriately and safely performed in an ASC will be reimbursed by the Department. In addition, the Department may add surgical procedures to the listing developed by the Medicare program as required by 42 CFR 416.65 if the procedures meet the criteria identified in 42 CFR 416.65 (a) and (b). (9-30-84)

a. The Department will provide a list of approved procedures to all participating ASCs. (9-30-84)

b. Such lists will be updated by the Department as new procedures are approved by the Medicare program. All participating ASCs will be notified by the Department of such changes. (9-30-84)

c. The recipient's medical diagnosis and the condition which requires the use of the prosthetic and/or orthotic services, supplies, equipment and/or modifications; and (10-1-91)

d. All modifications to the prosthetic or orthotic device must be supported by the attending physician's description on the prescription; and (10-1-91)

e. Requests lacking the required information shall be denied and returned to the applicant. (10-1-91)

02. Program Requirements. The following program requirements will be applicable for all prosthetic and orthotic devices or services authorized by the Department: (10-1-91)

a. A temporary lower limb prosthesis shall be authorized by the Department when documented by the attending physician that it is in the best interest of the recipient's rehabilitation to have a temporary lower limb prosthesis prior to a permanent limb prosthesis. A new permanent limb prosthesis shall only be requested after the residual limb size is considered stable; (10-1-91)

b. A request for a replacement prosthesis or orthotic device must be justified to be the least costly alternative as opposed to repairing or modifying the current prosthesis or orthotic device; (10-1-91)

c. All prosthetic and orthotic devices that require fitting shall be provided by an individual who is certified or registered by the American Board for Certification in Orthotics and/or Prosthetics; (10-1-91)

d. All equipment that is purchased must be new at the time of purchase. Modification to existing prosthetic and/or orthotic equipment will be covered by the Department; (10-1-91)

e. Prosthetic limbs purchased by the Department shall be guaranteed to fit properly for three (3) months from the date of service; therefore, any modifications, adjustments, or replacements within the three (3) months are the responsibility of the provider that supplied the item at no additional cost to the Department or the recipient; (10-1-91)

f. Prosthetic and/or orthotic equipment actually supplied to the recipient shall be the equipment approved by the Department; (10-1-91)

g. Not more than ninety (90) days shall elapse between the time the attending physician orders the equipment and the preauthorization request is presented to the Department for consideration; (10-1-91)

h. A reusable prosthetic or orthotic device purchased by the Department will remain the property of the Department and return of the device to the Department may be required when: (10-1-91)

i. The recipient no longer requires the use of the device; or (10-1-91)

ii. The recipient expires. (10-1-91)

03. Program Limitations. The following limitations shall apply to all prosthetic and orthotic services and equipment: (10-1-91)

a. No replacement will be allowed for prosthetic or orthotic devices within sixty (60) months of the date of purchase except in cases where there is clear documentation that there has been major physicial change to the residual limb, and ordered by the attending physician; (10-1-91)

a. Plastic or polycarbonate lenses will be purchased only when there is clear documented evidence that the thickness of the glass lenses precludes their use (prescriptions above plus or minus two (2) diopters of correction); (10-1-91)

b. When plastic or polycarbonate lenses are required, scratch resistant coating shall be purchased; (10-1-91)

c. Payment for tinted lenses will only be made when there is a diagnosis of albinism; (10-22-93)

d. Contact lenses will be covered only with documentation that an extreme myopic condition requiring a correction equal to or greater than minus four (-4) diopters, cataract surgery, or keratoconus preclude the use of conventional lenses. (10-22-93)

03. Replacement Lenses. Replacement lenses shall be purchased from qualified providers only with documentation of a major visual change as defined by the Department. Statements of major visual change shall include documentation of a visual refraction change of at least one-half (.50) diopter plus or minus. (10-1-91)

04. Frames. Frames will be purchased from qualified providers according to the following guidelines: (10-1-91)

a. One (1) set of frames will be purchased by the Department not more often than once every four (4) years for eligible recipients; (10-1-91)

b. Except when it is documented by the physician that there has been a major change in visual acuity that cannot be accommodated in lenses that will fit in the existing frames, new frames also may be authorized. (10-22-93)

05. Glasses. Broken, lost, or missing glasses shall be the responsibility of the recipient. (10-22-93)

123. OPTOMETRIST SERVICES. Optometrist services are provided to the extent specified in the individual provider agreements entered into under the provisions of Section 040. (12-31-91)

01. Payment Availability. Payment for services included in Subsections 070.02.d. and 122. is available to all licensed optometrists. (12-31-91)

02. Provider Agreement Qualifications. Optometrists who have been issued and who maintain certification under the provisions of Sections 54-1501 and 54-1509, Idaho Code, qualify for provider agreements allowing payment for the diagnosis and treatment of injury or disease of the eye to the extent allowed under Section 54-1501, Idaho Code, and to the extent payment is available to physicians as defined in these rules. (10-25-88)

124. PROSTHETIC AND ORTHOTIC SERVICES. The Medical Assistance Program will purchase and/or repair medically necessary prosthetic and orthotic devices and related services which artificially replace a missing portion of the body or support a weak or deformed portion of the body within the limitations established by the Department. (10-1-91)

01. Required Physician Orders. Prosthetic and orthotic devices and services will be paid for only if prescribed by a physician and preauthorized by the Department. The following information shall be provided with the physician's orders: (10-1-91)

a. A full description of the services requested; and (10-1-91)

b. Number of months the equipment will be needed and the recipient's prognosis; and (10-1-91)

04. Payment Methodology. ASC services reimbursement is designed to pay for use of facilities and supplies necessary to safely care for the patient. Such services are reimbursed as follows: (9-30-84)

a. ASC facility service payments represent reimbursement for the costs of goods and services recognized by the Medicare program as described in 42 CFR, Part 416. Payment levels will be determined by the Department. Any surgical procedure covered by the Department as described in Subsection 121.03. but which is not covered by Medicare will have a reimbursement rate established by the Department. (5-25-93)

b. ASC facility services will include, but not be limited to, the following: (9-30-84)

i. Nursing, technician, and related services; and (9-30-84)

ii. Use of ASC facilities; and (9-30-84)

iii. Drugs, biologicals, surgical dressings, supplies, splints, casts, and appliances and equipment directly related to the provision of surgical procedures; and (9-30-84)

iv. Diagnostic or therapeutic services or items directly related to the provision of a surgical procedure; and (9-30-84)

v. Administration, record-keeping and housekeeping items and services; and (9-30-84)

vi. Materials for anesthesia. (9-30-84)

c. ASC facility services do not include the following services: (10-1-91)

i. Physician services; and (9-30-84)

ii. Laboratory services, x-ray or diagnostic procedures (other than those directly related to the performance of the surgical procedure); and (9-30-84)

iii. Prosthetic and orthotic devices; and (9-30-84)

iv. Ambulance services; and (9-30-84)

v. Durable medical equipment for use in the patient's home; and (9-30-84)

vi. Any other service not specified in Subsection 121.04.b. (12-31-91)

122. VISION SERVICES. The Department will pay for vision services and supplies in accordance with the following guidelines and limitations: (10-1-91)

01. Eye Examinations. The Department will pay participating physicians and optometrists for one (1) eye examination during any twelve (12) month period for each eligible recipient to determine the need for glasses to correct a refractive error. Each eligible MA recipient, following a diagnosis of visual defects and a recommendation that eyeglasses are needed for correction of a refractive error, can receive eyeglasses within Department guidelines (See Section 100.). (12-31-91)

02. Lenses. Lenses, single vision or bifocal will be provided when there is documentation that the correction need is equal to or greater than plus or minus one-half (.50) diopters. (10-29-92)

b. Refitting, repairs or additional parts shall be limited to once per calendar year for all prosthetics and/or orthotics unless it has been documented that a major medical change has occurred to the limb, and ordered by the attending physician. (10-1-91)

c. All refitting, repairs or alterations require preauthorization based on medical justification by the recipient's attending physician; (10-1-91)

d. Prosthetic and orthotic devices provided for cosmetic or convenience purposes shall not be covered by the Department. These items include, but are not limited to, breast implants, penile implants and artificial eyes; (10-1-91)

e. Electronically powered or enhanced prosthetic devices are not covered by the program; (10-1-91)

f. The Department will only authorize corrective shoes or modification to an existing shoe owned by the recipient when they are attached to an orthosis or prosthesis or when specially constructed to provide for a totally or partially missing foot; (10-1-91)

g. Shoes and accessories such as mismatch shoes, comfort shoes following surgery, shoes to support an overweight individual, or shoes used as bandage following foot surgery, arch supports, foot pads, metatarsal head appliances or foot supports are not covered under the program; (10-1-91)

h. Corsets are not a benefit of the program nor are canvas braces with plastic or metal bones. However, special braces enabling a patient to ambulate will be covered when the attending physician documents that the only other method of treatment for this condition would be application of a cast. (10-1-91)

04. Billing Procedures. The Department will provide billing instruction to providers of prosthetic or orthotic services. A copy of the preauthorization must be attached to the claim form when submitted. (10-1-91)

05. Fees and Upper Limits. The Department will reimburse according to Subsection 060.04. (12-31-91)

125. DENTAL SERVICES. (10-1-91)

01. Dental Services-Listing. Dental services include diagnostic, preventive, restorative treatment, relief of dental pain and are purchased from a licensed dentist. Unspecified procedures will not be covered unless preauthorized. The following specific procedures are included in dental services: (10-1-91))

a. Initial oral exam; and (10-1-91)

b. Recall; and (10-1-91)

c. Full mouth x-rays, including necessary bitewing x-rays; and (10-1-91)

d. Intra-oral periapical, single film, first; and (10-1-91)

e. Intra-oral periapical, each additional film; and (10-1-91)

f. Bitewings; and (10-1-91)

g. Panographic survey; and (12-14-92)

h. Prophylaxis, adult complex; and (10-1-91)

i. Prophylaxis, child to age fifteen (15), simple; and (10-1-91)

j. Topical application of fluoride excluding prophylaxis; and (10-1-91)

k. Space maintainer, fixed, unilateral band or crown type; and (10-1-91)

l. Space maintainer, fixed, bilateral band or crown type; and (10-1-91)

m. Amalgams; and (10-1-91)

n. Retention pins; and (10-1-91)

o. Silicate cement, per restoration; and (10-1-91)

p. Acrylic or plastic; and (10-1-91)

q. Composites; and (10-1-91)

r. Crown, jacket, plastic; and (10-1-91)

s. Crown, jacket, plastic - prefabricated, crown full - porcelain fused to nonprecious alloy; and (10-1-91)

t. Crown, stainless steel; and (10-1-91)

u. Dowel pin; and (10-1-91)

v. Re-cement crown; and (10-1-91)

w. Pulp cap; and (10-1-91)

x. Pulpotomy; and (10-1-91)

y. Root canal therapy; and (10-1-91)

z. Apiceotomy, performed as separate surgical procedure; (10-1-91)

aa. Complete denture, upper; and (10-1-91)

bb. Complete denture, lower; and (10-1-91)

cc. Partial denture, upper or lower, with or without clasps, acrylic, flipper-stayplate; and (10-1-91)

dd. Denture adjustments; and (10-1-91)

ee. Relining or rebasing upper or lower complete denture; and (12-14-92)

ff. Extraction, simple; and (10-1-91)

gg. Extraction, surgical erupted tooth; and (10-1-91)

hh. Extraction, surgical, soft tissue impaction; and (10-1-91)

ii. Extraction, surgical, partial bony impaction; and (10-1-91)

jj. Extraction, surgical, complete bony impaction; and (10-1-91)

kk. Palliative (emergency) treatment of dental pain, minor procedures; and (10-1-91)

11. Pit and fissure sealants. (10-1-91)

02. Dental Services-Limitations. (7-1-93)

a. All hospitalizations must have prior approval; and (10-1-91)

b. Any dental service not listed in the Benefit Schedule is not covered; and (10-1-91)

c. Restoration of primary lateral and central incisors after the fifth birthday are not allowed. Teeth numbers D, E, F, G, N, O, P, and Q are the nonallowed teeth; and (10-1-91)

d. Space maintainers after the tenth birthday are not a covered benefit; and (10-1-91)

e. Denture reline not allowed for six (6) month after original placement and then once in a two (2) year period. (12-14-92)

f. Denture construction no more frequent than every five (5) years; and (10-1-91)

g. Denture adjustments not allowed for six (6) months following placement by same dentist who provided denture. (12-14-92)

h. Full mouth x-rays no more frequent than every three (3) years; and (10-1-91)

i. Panographic x-rays no more frequent than every twelve (12) months; and (10-1-91)

j. A maximum of four (4) bitewing x-rays allowed every six (6) months; and (10-1-91)

k. Restoration of the same tooth, same surface, no more than every two (2) years; and (10-1-91)

l. Initial oral exams allowed every twelve (12) months; and (10-1-91)

m. Recall exam allowed once every six (6) months; and (10-1-91)

n. Oral prophylaxis no more frequent that one (1) every six (6) months; and (10-1-91)

o. Topical fluoride applications will be allowed every six (6) months; and (10-1-91)

p. Topical fluoride given as a fluoride paste prophy will be paid as prophy only according to patient's age; and (10-1-91)

q. Restorative services which are cosmetic in nature are not covered; and (10-1-91)

r. More than one (1) restoration in the same tooth surface is not covered; and (10-1-91)

s. Periodontal scaling and root planning covered once in a twelve (12) month period. (12-14-92)

t. Periodontal maintenance covered once in a six (6) month period. (12-14-92)

u. Acid etch as a separate procedure is not allowed; and (10-1-91)

v. Oral hygiene instruction is not a benefit; and (10-1-91)

w. Medicated bases or liners are not covered as a separate procedure from the restoration; and (10-1-91)

x. Local anesthetics fees are not covered as a separate charge; and (10-1-91)

y. Polishing and finishing charges are not covered as a separate charge; and (10-1-91)

z. Procedures not recognized by the American Dental Association are not covered; and (12-14-92)

aa. Root canal procedures are limited to permanent teeth; and (10-1-91)

bb. Fixed bridgework is not covered; and (10-1-91)

cc. Orthodontic services will be a benefit for EPSDT eligible children under age twenty-one (21) years only with preauthorization as determined by the handicapping malocclusion Index (DHEW Pub. #77-1644). (11-6-93)

dd. Orthodontic Services are not benefits for persons after their twenty-first (21st) birthday. (12-14-92)

ee. Occlusal sealants will be limited to permanent molars and premolars for recipents age six (6) years to sixteen (16) years. Service is also limited to once per tooth in a three (3) year period. (12-14-92)

03. Dental Services-Procedures. Dental service procedures are as follows: (10-1-91)

a. If a dental provider determines that hospitalization is necessary for the dental treatment, a request in writing must be submitted to the Department prior to the hospitalization and written preauthorization received from the Department's dental consultant. (10-1-91)

b. If, in the opinion of a dental provider, a condition exists such that orthodontic correction of a severely handicapping malocclusion is vital to the physical and emotional well-being of the individual, a request in writing must be submitted to the Department for prior approval. Supporting evidence of need must be presented and is to include x-rays and plaster casts which demonstrate the severity of the malocclusion (See Title 3, Chapter 19, Subsection 025.02.z.). (12-31-91)

c. Unspecified procedures can be submitted for review to determine if the procedure can be pre-authorized. X-Rays and written justification are required. (12-14-92)

04. Dental Payment Procedure. (12-31-91)

a. The Department will pay the lower of either the billed charge or the state's maximum reimbursement rate (See Section 060.); (12-31-91)

b. All dental claims must be submitted on the American Dental Association (ADA) claim form. (10-1-91)

126. PRESCRIPTION DRUGS. The Department will pay for those prescription drugs not excluded by Subsection 126.02. which are legally obtainable by the order of a licensed physician, dentist, osteopath, nurse practitioner, or podiatrist. Prescriptions for diaphragms and oral contraceptives as well as contraceptive supplies and intrauterine devices are also eligible for payment under Subsection 090.01. (12-31-91)